REMARKS OF U.S. REPRESENTATIVE JOHN E. FOGARTY
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DISABILITY

A NATIONAL HEALTH PROBLEM AS SEEN FROM CAPITOL HILL

I accepted with pleasure this invitation to appear here tonight, because I welcome every opportunity to participate in an activity whose aim is to improve the health of the American people. This seminar today is such an activity.

I have been asked to talk to you this evening on disability, a subject that is of as much concern to me as a legislator as it is to you as physicians and health workers, although from a somewhat different point of view.

Health matters have traditionally been a great concern of law as well as of medicine. The history of health legislation is almost as old as the history of lawmaking itself in this country. Let me go back for just a moment to these earliest efforts on the part of governing bodies to halt the inroads of disease on the citizens of our first colonies. Our earliest health laws were related almost exclusively to the spread of disease through travel, which was originally of special importance in maritime traffic and more recently has become important in air traffic.

In Colonial America, the earliest quarantine restriction, to halt the spread of disease from foreign ships, was enacted in 1647 by the Massachusetts Bay Colony against ships arriving from Barbados, and in 1700 the Province of Pennsylvania enacted legislation "to prevent sickly vessels coming into the government."

Although the original legislative health efforts were directed specifically against communicable diseases entering by sea, governing authorities began to develop broader health concerns as early as 1754 when the Colonial Government of New York imposed a tax on all seamen and passengers entering the port of New York, and with these funds provided not only quarantine hospital accommodations but established the first city dispensaries and provided financial support to the Society for the Reformation of Juvenile Delinquents.

In 1798 the U.S. Public Health Service, now the principal health agency of our Country, was created as a Marine Hospital Service when an act of Congress providing for the relief of sick and injured seamen was signed by President John Adams. Proponents of the Act were not concerned with the humanitarian considerations alone, but argued also that the National defense demanded a National program of direct medical and hospital care for seamen, since the merchant fleet had always been a major element of the Nation's naval defense.

In the more than a century and a half which followed these pieces of legislation, Congress has often demonstrated its continuing

interest in the health of the American people. This interest is based upon a conviction that a healthy nation is a productive nation and that a general state of National health is an economic asset and an essential component of defense even if there were no human issues involved. This Congressional concern has been reflected in such laws as these:

Legislation to control a third "killer" disease was enacted in 1833 as the result of a widespread outbreak of cholera, and authorized the use of revenue cutters in enforcing quarantine laws of States and cities.

The world-wide pandemic of influenza in 1918 stimulated Congress to appropriate one million dollars for the Public Health Service to use in suppression of influenza in the United States. In the 20's, the Veterans Bureau, later to become the Veterans Administration, and the Bureau of Indian Affairs were both established by law.

And so it has gone, with each decade bringing new laws relating to health and disease control.

A new dimension of health concern began with the National Health Survey of 1935, the first definitive survey of health to determine the relationship of disease and certain environmental factors such as income, education, and housing conditions. This survey brought together for the first time information that formed a basis for Federal, State, and local action directed toward the prevention and control of the chronic as well as the communicable diseases, and stimulated the

development of programs aimed at the bettering of social and economic conditions among the deprived of our Nation.

Beginning with the impact of the findings of the first National Health Survey, and given additional impetus from World War II, there has been a gradual but substantial shift of legislative perspective in regard to health. This has evolved as a response to the changing health needs of a changing society. That our society has changed, few persons would argue.

For example, while by no means entirely eliminated from the health picture, the communicable diseases and the sanitation problems incident to these no longer have a dominant claim on either medical or legislative attention. Just as our society has changed greatly in the past 30 years, so it will no doubt continue to change, at least into the foreseeable future. A glance at the population figures reveals one very basic factor: we are becoming a Nation of the very young and the very old. We have increased our life expectancy to span the decades in which chronic diseases are increasingly common and their crippling effects more disabling.

We have managed to control the great killers of the past -- yellow fever, smallpox, cholera -- but we have created new killers and cripplers to take their place. Heart disease, cancer, and stroke claim over a million lives every year and disable many more. Vehicles with fatal highway speeds cause mass crippling in the youth of our land.

We have acquired great technological skill, but with it a longer life span in which to develop social and economic hardships in the so-called "golden years".

We have, in short, set the stage for disability. For nearly a century we have collected statistics on mortality. Only in recent years have we really begun to realize the vast implications -- of chronic and malignant diseases, of injuries and old age -- for those who do not appear on our mortality tables because they are not yet dead.

What are some of these implications? In the three great killer diseases I have just mentioned -- heart disease, cancer, and stroke -- death itself is not the only tragedy. If those individuals we have listed in the statistical tables as "survivors" are merely snatched from the jaws of death to become doomed to a bedfast existence at home or in the back wards of public institutions then the advances merit only limited praise. There is abundant evidence, however, that disability no longer need be accepted as the natural and inevitable aftermath of cancer surgery, or heart disease, or stroke, or old age; evidence that disability can be prevented or minimized; evidence that knowledge already available could be more fully utilized to offer useful and productive years to be lived in dignity by millions of chronically ill and aged persons.

I am referring, of course, to that area of medical care known as medical rehabilitation. For in this portion of comprehensive health care lies our conception of medical science as a tool for health, rather

than limiting it to the bare provision of basic bodily survival. We have in the past directed our major medical and legislative efforts toward those activities -- from immunization to organ transplant -- designed to prevent death. But we have an additional obligation to those whom we have rescued -- we must insure that that life is worth living. We must do more than substitute one tragedy for another. And this is where medical rehabilitation comes into focus.

The respect I have for those who cultivate the fields of rehabilitation is profound. I have come to know many of these workers well. Through the work of the appropriations subcommittee which I have chaired for several years, I too have endeavored to serve the disabled people of this country. In these years I have had an opportunity to gain an understanding of the national problem posed by disability and an awareness of the obstacles to delivery of medical rehabilitation services to those who need and could benefit from them. I have come to understand that medical rehabilitation, or disability control, or whatever you choose to call it, has vast potentials, not only in restoring the disabled to a high level of independence, but in preventing disability from developing.

Those of you here today are demonstrating by your presence at this seminar on the management of the chronic disease patient your concern for better care of this segment of the population. You and your counterparts in other sessions of this type are seeking to

expand the horizons of medical care for this neglected group. You are denying, in effect, the validity of medical attitudes which claim that nothing can be done for those so unfortunate as to be afflicted with chronic diseases and old age. You are attempting to find solutions to the common problems associated with disability. We have learned by now that shutting the disabled out of sight accomplishes nothing. We can never build enough custodial "boxes" even for this. And we should not try.

In the process of gathering information relative to disability and to the need for rehabilitative services throughout the country, I have come to view rehabilitation in its broadest sense -- health care concerned with preventing disability and maintaining function, as well as restorative services to those with existing impairments -- as the window on the future. I am convinced that health measures enacted by Congress and health services provided by physicians and other health professionals must all take into account the chronicity of many illnesses and conditions. In our fight for life-saving techniques, let us make sure that it is really the whole life we are saving. Let our philosophy be based on reality, and let our goals be based on a belief in the true worth of man.

Workers in public health know that when large numbers of people need health services which in the usual course of events they do not receive, then it becomes a public health problem. When such a need is widespread, then it becomes also a national problem and of

concern to legislative authorities. That there has been legislative recognition of such national health problems is evident in such laws as the following:

The Community Health Services and Facilities Act of 1961, which provides for demonstrations of new methods of providing community health services, including a variety of rehabilitation services.

The Health Professions Educational Assistance Act of 1963 and the Nurse Training Act of 1964 are both designed to increase professional health manpower, for without sufficient personnel to provide health services, the most desirable and effective medical program falls short of its goal.

The Heart Disease, Cancer, and Stroke Amendments of 1965 which assigns responsibility to the Public Health Service for encouraging and assisting the establishment of regional cooperative arrangements among medical schools, research institutions and hospitals, designed to forge a closer link between the centers of scientific and academic medicine on the one hand, and community health services on the other. This legislation specifies that this forthright program must not interfere with present patterns of patient care and professional practice, but it is nonetheless a revolutionary piece of legislation. It is designed to develop and disseminate medical knowledge of treatment techniques through cooperative efforts of medical resources in the community.

Nowhere in the legislation, or in the testimony in its support before the Congressional committees, will you find a blueprint for this program -- because there is no Federal blueprint and it is not intended that there should be one. The pattern of grants-in-aid, already so well established and so successful in the support of medical research, will also be followed in this new program. These grants will be made in response to local initiative, to facilitate local planning, and to assist local execution of the plans. The emphasis of this program is clearly on bringing this country's proven research capability -- as reflected in the medical schools and research hospitals -- into a closer relationship with medical practice, as a resource for the practitioner, the local hospital, and the community health services in a wide geographic area.

The Social Security Amendments of 1965, which provide health insurance benefits to the aged and is popularly known as "Medicare". This legislative package evolved out of a recognition that it is one thing to have improved medical service, but quite another thing to pay for it. The rapid and dramatic increase in the costs of hospital care and health services generally is alarming. It is alarming because it means that despite our general prosperity we are still putting some forms of medical care beyond the reach of many of our citizens. This is not a tolerable situation. I am not contending that the charges made for medical services are excessive in relation to costs, or in relation to value but merely that they are still too often excessive in

relation to ability to pay. Fear of the doctor's bill or the hospital bill should not be the factor that keeps members of any economic group from availing themselves of medical care.

There is another aspect to this problem of costs which disturbs me. This is the attempt to extend to the field of health services and medical research the concepts of cost-benefit economics generated by our defense and space technology. These approaches start off with the assumption that every public act must be weighed in terms of its economic rate of return. This is a concept which we must reject out of hand. It involves a principle which cannot be applied to health.

This is not to say that there are never economic savings as a direct result of medical care. Certainly, the nearly 200,000 vocationally rehabilitated persons each year are returning to the labor market and paying taxes where formerly they contributed only to the costs of medical care, or prevented a family member from being employed. But there are millions of citizens with no employment potential. Those over 40, handicapped and uneducated for other than manual tasks; those with deteriorating chronic diseases; those past retirement. What of these? How do we measure the dollar costs to society of <u>not</u> providing them with necessary health services? And if we could do this, would it be in any way a yardstick of the human values involved?

There will be new advances in medical science in the years to come, and there will be new laws relating to health. Hopefully, breakthroughs in preventing death will lead to enriching human life as well, and emerging legislation will consider the human above the economic values of life. Medicine and law have been partners for generations in this land of ours. I expect this to continue into more and more areas, such as poverty -- which goes hand in hand with disease and disability -- and old age -- which has outlived the killer diseases of youth only to fall heir to the chronic diseases in later years -- and ignorance -- which prevents the delivery of appropriate health services to all who need them.

Only then, when all men have the opportunity to achieve and to maintain their highest potentials, may we -- the health professions and the lawmakers -- rest upon our laurels secure in the knowledge that we have done our job faithfully and completely.